

Date: June 4, 2001

DSL-BQA-01-029

To: Home Health Agencies

HHA - 14

From: Jan Eakins, Chief
Provider Regulation and Quality Improvement Section

cc: Susan Schroeder, Director
Bureau of Quality Assurance

Outcome and Assessment Information Set (OASIS) Update

The purpose of this memorandum is to provide you with information related to:

- New OASIS correction policy for home health agencies (HHAs).
- Applicability of OASIS requirements and the Medicare Conditions of Participation (CoP).
- Frequently asked questions related to OASIS.
- Resources.

New OASIS Correction Policy for HHAs

The Bureau of Quality Assurance (BQA) received the attached memorandum, Ref: S&C 01-12, dated April 20, 2001, from the Health Care Financing Administration (HCFA), Survey and Certification Group. The memo, effective May 7, 2001, explains the new OASIS correction policy for HHAs, which was included in the spring release updating the State OASIS System. This new policy, called inactivation, enables HHAs to remove erroneous OASIS records and make key field changes to records that have been accepted by the State OASIS System.

Applicability of OASIS Requirements and the Medicare CoP

BQA received the attached Electronic Regional Program Letter #2000-30, dated November 17, 2000, from HCFA, Chicago Regional Office. This letter provides questions and answers that relate to the applicability of OASIS requirements and the Medicare Conditions of Participation (CoP).

Frequently Asked Questions

HHAs may refer to the attached BQA document titled "OASIS Frequently Asked Questions" for help in understanding OASIS policies. This document contains responses to questions that BQA staff frequently receive and also questions received at the April BQA sponsored OASIS: Beyond the Basics workshops. The questions are divided into categories for easy reference.

The BQA also posts frequently asked questions with their appropriate responses on the State OASIS System website under Bulletins. The date is noted each time that the Bulletins area is updated. The Bulletins area is a quick way to convey information to providers, so please check this website frequently.

Resources

Please direct questions, including questions related to the attached HCFA memos, to the resource contacts listed below:

Software and OASIS data transmission:

- Chris Benesh, OASIS Automation Coordinator, 608/266-1718 or benesce@dhfs.state.wi.us.
- Cindy Symons, OASIS Technical Analyst, 608/266-9675 or symoncg@dhfs.state.wi.us.

OASIS clinical issues:

- Andrea Henrich, OASIS Education Coordinator, 608/267-3807 or henriam@dhfs.state.wi.us.

Home health regulations:

- Barbara Woodford, Nurse Consultant, 608/264-9896 or woodfba@dhfs.state.wi.us.

Pharmacy/medication issues:

- Douglas Englebert, Pharmacy Practice Consultant, 608/266-5388 or engleda@dhfs.state.wi.us.

Medicare payment and billing issues:

- Medicare Provider Relations at United Government Services, 1-877-309-4290.

Attachments

HEALTH CARE FINANCING ADMINISTRATION
Chicago Regional Office, Midwest Consortium

Electronic Regional Program Letter #2000-30

DATE: November 17, 2000

FROM: HCFA, Chicago Regional Office
Division of Survey and Certification

SUBJECT: HHA Questions and Answers - INFORMATION

TO: State Survey Agency Directors

The following questions and answers relate to the applicability of the Outcome and Assessment Information Set (OASIS) requirements and the Medicare conditions of participation (CoP). Therefore, we would like to preface our responses with the following general information.

Preface:

The Medicare CoP for home health agencies (HHAs) apply to all patients served by the HHA, regardless of payment source, and not just Medicare patients, unless the condition is specifically limited to Medicare beneficiaries. The Health Care Financing Administration's (HCFA) policy in this area is longstanding. Sections 1891(a) and 1861(o)(6) of the Social Security Act refer to an HHA meeting the HHA CoP, not just as they apply to Medicare beneficiaries. While the purpose of the CoP is to help ensure proper care of Medicare beneficiaries, the CoP do this by defining the standards for an agency in which Medicare beneficiaries may be treated, instead of setting out the requirements applicable only to the care of Medicare patients served by the HHA.

The comprehensive assessment and OASIS data collection requirements apply to Medicare certified HHAs, and, to Medicaid home health providers in States where those agencies are required by the State to meet the Medicare CoP. The comprehensive assessment and OASIS data collection requirement currently applies to all patients receiving skilled care, including Medicare, Medicaid, managed care, and private pay patients with the following exceptions: 1) patients under the age of 18; 2) patients receiving maternity services; and 3) patients receiving only chore or housekeeping services. OASIS requirements have been delayed for patients receiving only personal care (non-skilled) services. The encoding and transmission requirement currently applies to Medicare and Medicaid patients only. A detailed explanation of the current requirements and timing of future requirements appears on HCFA's OASIS web page at <http://www.hcfa.gov/medicaid/oasis/oasishmp.htm>.

Some of the questions also relate to the HHA providing non-covered care to the Medicare beneficiary. As a part of the patient rights CoP, the HHA is required to advise the patient, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. (See 42 CFR 484.10)

The specific questions and answers follow:

1.Q. Can we provide palliative care services through our HHAs for those patients who are not homebound or not within 6 months of death.

A. Medicare approved HHAs may provide palliative care services to patients who are not homebound or not within 6 months of death if the patients are under a plan of care (PoC) signed by the physician and all other CoP are met. Of course, coverage and eligibility rules may prevent Medicare payment for those services.

2.Q. Can we provide one time only visits such as 1 physical therapist visit for home safety evaluation, 1 registered nurse visit for lab draw, or 1 social work visit

for planning or community resources? Would these patients be subject to all of the CoP requirements, i.e. OASIS, PoC, complete clinical record and discharge?

A. One time only visits may be provided to patients of an HHA. All patients in a Medicare certified HHA would be subject to all of the COP requirements, including the OASIS, PoC and complete clinical record regardless of how brief the visit schedule. All patients are subject to the OASIS requirements if the service provided is skilled. Of course, coverage and eligibility rules may prevent Medicare payment for those services.

3.Q. Can we provide visits to non-homebound patients? If done as part of the HHA, would they be subject to all CoP requirements, i.e. OASIS, PoC, complete clinical record and discharge?

A. A Medicare approved HHA may provide services to non-homebound patients as long as it continues to meet the Medicare CoP. Medicare patients who are not home bound would not meet the eligibility requirement for payment under the Medicare home health benefit. See preface for applicability of OASIS and CoP requirements.

4.Q. Can we provide disease management programs for ongoing supervision to HHA patients who would normally be discharged when no longer homebound or who are stabilized but would not qualify for MAE? Would these patients be subject to all COP requirements, i.e. OASIS, PoC, complete medical record, and discharge?

A. Yes. The CoPs would continue to apply although the OASIS requirements would not currently apply once the patient no longer required skilled care. See preface.

5.Q. If we provided a disease management or palliative care program do we need to separate the records in any way? Would record maintenance be subject to CoP and State Regulations?

A. All patients accepted for care by the HHA are subject to the CoP. This includes the clinical record condition.

6.Q. For any non-Medicare patients in scenarios listed above, how would we track and report the visits on cost reports and State reports?

A. Please check with your Fiscal Intermediary regarding cost reports and the State Office of Licensing and Certification for the State reports.

7.Q. How would the costs associated with these non-Medicare patients be allocated on the cost report? Would we use a non-reimbursable cost center?

A. See the answer at Number 6.

8.Q. Could we provide an MSW (for one or more visits) when social problems existed but no need for skilled nursing or skilled rehab? If so, would a nurse have to do OASIS, PoC, complete medical record, and discharge?

A. The MSW can visit the patient for one or more visits; however, since the HHA must comply with the CoP for all patients accepted for care, the HHA is responsible for assuring that the comprehensive assessment and OASIS requirements are fulfilled as well as all other CoP. Since the MSW cannot complete the comprehensive assessment under the OASIS requirements, the RN would need to perform the comprehensive assessment and any other required assessments.

9.Q. Can a MSW continue to visit the patient after other skilled services have stopped, provided Medicare is not billed for the visit? If so, would the nurse need to make a discharge visit to complete OASIS after the MSW discharges the patient?

A. The registered nurse is responsible for completing the OASIS discharge assessment in this situation, when the patient is discharged from the HHA.

10.Q. Can we provide aide services only? We would plan to have an RN set up the PoC and supervise at least every 62 days. Would these patients be subject to all COP requirements, i.e.OASIS, PoC, complete clinical record, and discharge?

A. A Medicare approved HHA may provide aide services only to some of its patients. The CoP apply, although the OASIS requirements for personal care only patients are delayed. (See preface.)

Any questions or comments on this program letter should be directed to the Non-Long Term Care Branch Manager, Robert Daly, at (312) 886-5344.

/s/

Charles Bennett
Branch Manager
Survey and Certification Program
Coordination and Improvement

Outcome and Assessment Information Set (OASIS) Frequently Asked Questions

Applicability

Q1. Does OASIS have to be collected on insurance patients?

A1. The comprehensive assessment and OASIS data collection requirement currently applies to all patients receiving skilled care, including Medicare, Medicaid, managed care, private insurance and private pay patients with the following exceptions: 1) patients under the age of 18; 2) patients receiving maternity services, and 3) patients receiving only chore or housekeeping services. OASIS requirements have been delayed for patients receiving only personal care (non-skilled) services.

The encoding and transmission requirement currently applies only to Medicare and Medicaid patients receiving skilled care. The requirement for home health agencies (HHAs) to encode and transmit OASIS data on their private pay patients will be effective after publication of a Federal Register Notice announcing the effective date. This notice is currently in clearance and we are unable to speculate on a publication date.

Q2. What is the purpose of completing a start of care OASIS assessment on a PRN visit for a Medicaid patient that has no further visits planned? Does this generate data?

A2. As stated above, federal regulations require HHAs to complete the comprehensive assessment and OASIS data collection on all patients receiving skilled care. If the PRN visit is for skilled care, OASIS requirements apply, even if the visit is a one-time visit. (An exception to this requirement may occur with the administration of influenza and/or pneumonococcal vaccines. Refer to HCFA OASIS Q&As # 9 and #10 at: <http://www.hcfa.gov/medicaid/oasis/hhqcat01.htm>)

If Reason for Assessment (RFA) 02 (SOC - no further visits planned) is the only OASIS assessment submitted, two time points are not present and the patient will not appear in the Outcome Based Quality Monitoring (OBQM) reports.

Comprehensive Assessment

Q1. If a patient is discharged after a visit to the doctor, is it necessary to complete the discharge assessment? Is it necessary to make a home visit after the discharge order is obtained?

A1. If the physician determines that the patient does not need additional visits and requests discharge, the agency must report the patient status at the last skilled visit prior to this date. The agency should document that the discharge data is based on this last visit and the reason for using this data. When agency staff are aware that the patient's needs for home care are decreasing and that a physician visit is imminent, the possibility of such discharge must be

considered. Close attention to the details of the comprehensive assessment thus can be incorporated into the home visit scheduled prior to the physician visit.

Q2. What do we base an assessment on when there is an unplanned or unexpected discharge and the patient refuses a discharge visit?

A2. *HCFA has provided direction with examples for dealing with unplanned or unexpected discharges. Please refer to this discussion, question number 29, on the HCFA OASIS website: <http://www.hcfa.gov/medicaid/oasis/hhqcat11.htm>.*

Q3. Is it necessary to complete the OASIS discharge assessment on patients who are discharged after a hospital stay?

A3. *Patients transferred to an inpatient facility who are subsequently discharged by the agency without receiving additional visits/services do not require a discharge comprehensive assessment since the patient has not been under the care of the agency since the transfer. This patient will have had OASIS data reported at the point of transfer to the inpatient facility. The agency would have reported this data on the RFA 06, transferred to inpatient facility – not discharged from agency, or RFA 07, transferred to inpatient facility – is discharged from agency. No additional assessments or OASIS data collection are expected in this situation unless a resumption of care occurs. Therefore, if the patient does not return, the agency would complete a "paper discharge" for their records, as appropriate, but no OASIS data are reported.*

Q4. Who can perform the comprehensive assessment in the following situations?

- a) When RN and PT are both ordered at SOC?
- b) When PT is ordered at SOC and the RN will enter 7-10 days after SOC?
- c) When PT (or ST) is ordered along with an aide?
- d) For a therapy-only case, when agency policy is for the RN to perform an assessment before the therapist's SOC visit?
- e) OT services are the only ones ordered for a non-Medicare patient?
- f) Both RN and PT will conduct discharge visits on the same day?

A4. *According to the comprehensive assessment regulation, the following disciplines would perform the assessments in these situations:*

- a) *When both disciplines are ordered at SOC, the RN would perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.*
- b) *If the RN's entry into the case is known at SOC (i.e., nursing is scheduled, even if only for one visit), then the case is NOT therapy-only, and the RN should conduct the SOC comprehensive assessment. If the order for the RN is not known at SOC and originates from a verbal order after SOC, then the case is therapy-only at SOC, and*

the therapist can perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

c) Because this is considered a therapy-only case (i.e., therapy is the only skilled service), the PT (or ST) would perform the comprehensive assessment and all subsequent assessments.

d) A comprehensive assessment performed BEFORE the SOC date cannot be entered into HAVEN (or HAVEN-like software). Since the regulations allow for the comprehensive assessment to be conducted by the therapist in a therapy-only case, the agency may consider changing its policies so that the therapist could perform the SOC comprehensive assessment. If the agency chooses to have an RN conduct the comprehensive assessment, the RN could perform an assessment on or after the therapist's SOC date (within 5 days to be compliant with the regulation).

e) The OT can perform the assessment if OT services establish program eligibility.

f) Either discipline may perform the discharge comprehensive assessment.

Data Items

Q1. M0440: What is HCFA's interpretation of skin lesion in OASIS data item M0440?

A1. "Lesion" is a broad term used to describe an area of pathologically altered tissue. All primary and secondary skin lesions are considered lesions. Examples of primary lesions are: petechiae, ecchymosis, macule (freckle, flat mole), papule (wart), wheal (urticaria, insect bite). Examples of secondary lesions are: cyst, scar, scale, crust (scab), keloid, fissure, ulcer. For additional types of skin lesions, please consult a physical assessment textbook.

In responding to M0440, the only "lesions" that should be disregarded are those that end in "ostomy" (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites (central line sites are considered to be surgical wounds). The presence of ANY wound or lesion (other than ostomies or peripheral IV sites) should be noted by a "yes" response to M0440.

Q2. M0450: Is a pressure ulcer that has been surgically debrided considered a pressure ulcer or a surgical wound?

A2. A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not become a surgical wound. However, a muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer. Refer to OASIS Items in Detail in your OASIS Implementation Manual.

Q3. M0482: I have a question regarding wound and skin lesions and porta cath. If the patient has a porta cath, but the agency is not providing any services related to the cath and not accessing it, would this be coded as a skin lesion?

A3. If the patient has a porta cath, you would answer YES to M0440 for a lesion and continue answering the questions until you come to M0482 - Does this patient have a surgical wound? Respond Yes - #1. The porta cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion.

Outcome Based Quality Monitoring (OBQM) Reports

Q1. What is the recommended time period for reviewing the Adverse Event Outcome Report?

A1. The first time you obtain this report, you should get it for a one-year period. This is the default selection that will be made for you unless you make another selection. It is very important to have a picture of the pattern of adverse events over an entire year and also have a large enough sample of patients to conduct an investigation. After you have reviewed the Adverse Event Outcome Report that represents an entire year, it is then appropriate to select the report for quarterly reviews.

Q2. Is it OK to use Dr. Demming's Plan-Do-Check-Act performance improvement process instead of the quality monitoring process discussed in the OBQM manual?

A2. Every agency currently is required by the Medicare CoPs to monitor the quality of care it provides. It is very possible to integrate the investigations of the reports into your current activities and make the investigations a true part of your agency quality-monitoring program. In Section 4: Using Reports from the Outcome-Based Quality Monitoring Process of the manual, "Quality Monitoring Using Case Mix and Adverse Event Outcome Reports," tips are offered on how to involve your staff in investigating these reports. Using a chart audit tool is recommended as an approach. For example, a chart audit tool can be developed for use (and reuse) by a number of staff in your agency's current quarterly record review processes. It is very possible to integrate this process into an agency's current quality-monitoring program.

Q3. How is the "number of cases" on the Adverse Event Outcome Report calculated?

A3. The number of cases on the Adverse Event Outcome Report reflects the number of patients for whom each specific adverse event could have occurred. This number varies from one specific adverse event to another, primarily due to the selective inclusion of patients determined to be "at risk" for specific adverse events. Specific information on this selection process is not included in your OBQM Manual; however, you can infer this information by studying the following: Sources of Adverse Event Outcome Report Information, OBQM Manual, page 3.7, and Definitions of Specific Adverse Events, page 5 of the OBQM Manual Appendix. HCFA plans to publish the specifications for the OBQM reports on their website in the near future. More information on this topic would be available at that time.

Automation

Q1. We print out an OASIS audit on every OASIS we submit. Do we need to keep these as verification or is it enough to keep the monthly edits that we run before submission?

A1. There is no requirement to retain audit/edit reports that are created by your internal OASIS software system. This information may be helpful as a quality improvement tool to use to prevent future coding errors.

Q2. If data accuracy errors are found through analysis of the OBQM reports, how does the agency correct previous OASIS assessments that have been locked and submitted?

A2. Please refer to the attached HCFA memorandum that explains the new OASIS Correction Policy.

Q3. What is the effective date of an assessment?

A3. The effective date is used by the State OASIS System to uniquely identify OASIS records and to sequence records. The OASIS item that is used to determine the effective date varies depending on the Reason For Assessment (RFA). The Effective Dates are defined as follows:

(M0030) Start of Care Date for RFA 01 and 02

(M0032) Resumption of Care Date for RFA 03

(M0090) Information Completion Date for RFA 04 and 05

(M0906) Discharge/Transfer/Death Date for RFA 06, 07, 08, 09, and 10.

Q4. What actions does the HHA need to take when a fatal record error is received on the final validation report?

A4. The HHA must correct all rejected OASIS records that are valid records for patients whose assessments are required to be submitted to the State OASIS System, and are not a duplicate of a previously accepted record. No action is required for records that receive fatal record message 1000 - Duplicate assessment. Records with this message were previously submitted and accepted by the State OASIS System. All other rejected valid records must be corrected and resubmitted.

Q5. What are the consequences of the OASIS lock dates when you correct an OASIS data item?

A5. The OASIS reporting requirement allows HHAs 7 days to edit, data enter, and lock an OASIS assessment record. A new lock date must be entered for all OASIS records that are submitted to correct errors in previously accepted records. The 7 day locking requirement is waived for records that are submitted to correct non-key field errors on previously accepted records. Records submitted to correct key field errors will most likely have a lock date that is beyond 7 days from the assessment completion date and therefore will receive a late warning message. It is reasonable that the lock dates for these types of corrections may extend beyond the 7 day locking requirement.

Medicaid Billing

Q1. For Medicaid reimbursement, must the HHA check box A on the Advance Beneficiary Notice (ABN), stating that the patient wants a Medicare denial before billing Medicaid, even if the patient does not dispute the Medicaid billing?

A1. The following answer was provided by the Division of Health Care Financing: Medicaid does not require the ABN to be completed. When a provider knows that a service is not a Medicare benefit (non-covered, benefits exhausted, etc.), the provider may submit the claim directly to Medicaid, except in the following instances:

- 1. A claim for a Qualified Medicare Beneficiary (QMB) Only recipient.*
- 2. Medicare determines the service is not medically necessary.*

Use of a Medicare disclaimer may be necessary. Please refer to the All Provider Handbook, Coordination of Benefits section.

For Medicare requirements regarding ABN, refer to Medicare Provider Services at 1-877-309-4290.

Medicare Reimbursement

Answers to the following questions have been provided by United Government Services. For further questions or clarifications on Medicare policy, contact Medicare Provider Services toll free at 1-877-309-4290.

Q1. What does ROVER stand for:

A1. ROVER is the Regional Home Health Intermediary OASIS Verification Protocol.

Q2. Will ROVER become available to HHAs to assist in chart review?

A2. HCFA is considering making the ROVER software available to the provider community.

Q3. The client is going to a wound clinic daily or two times per week. Can they still be under homecare – Medicare with PPS?

A3. Leaving the home to obtain medical care does not make the beneficiary ineligible for receiving Medicare home health services. However, there must be medical justification to receive that care outside the home rather than through the home health agency.

Q4. Someone from our agency, who recently attended the NAHC National Policy Conference in Washington, understood one of the speakers to say that Medicare eligible patients requiring daily (or more frequent) visits for a finite and predictable period should NOT any longer be admitted as a Medicare patient (supposedly this was part of the 1997 BBA). Please comment.

*A4. UGS does not have any knowledge of this policy. If the daily care is **not** finite and predictable, then the beneficiary is not eligible for Medicare services.*

Q5. Regarding the ABN: If the patient is to receive the original ABN, is it acceptable to mail this back to the patient after photocopying for the agency, UGS and the physician? Please clarify the number of copies of the ABN that is needed per patient.

A5. You may mail the original back to the beneficiary. Note that this must be done within 30 days from the date the provider received the signed ABN from the beneficiary. Refer to page 4 of Program Memorandum A-01-15, dated January 16, 2001. A total of three copies plus the original are needed per beneficiary.

Q6. Regarding supplies: If a patient is discharged from the HHA before the end of the 60-day episode, is the HHA responsible for the supplies for the whole 60 days. A vendor of a patient states “yes”. Example: Start of care 2/10/01; Episode 2/10/01 to 4/10/01; Discharged 3/12/01. Shouldn’t the patient be able to order supplies as of 3/13/01 through their vendor and have Medicare pay for them?

A6. The home health agency is responsible through the date of discharge. Supplies needed after that date can be billed to Medicare Part B by the supplier. HHAs must be proactive in submitting their final claim so the episode is recorded as closed.

Q7. Would the home care agency be responsible for providing supplies to the patient after discharge but through the end date of certification period? We had a patient with a colostomy. He was discharged 30 days into the certification period with goals met. He called the vendor on the day of discharge to order supplies and they told him that home care had to provide supplies through the end date of the certification period. Is this correct?

A7. Please see above response to Question 5. The HHA is responsible through the date of discharge.